Current issues in fitness for work certification

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SUMMARY

This paper explores some current issues for certifying medical practitioners in the United Kingdom (UK), particularly general practitioners (GPs), who provide medical advice to their patients on fitness for work. Medical statements that doctors use to record this advice, such as form Med 3 and form Med 4, may be used by patients as evidence to support claims for financial benefits, including Statutory Sick Pay (SSP) and state incapacity benefits. The UK employment context for sick or disabled people of working age is beginning to change, but many barriers to work retention and work resumption still exist. The UK government has embarked on a wide range of reforms that are aimed at improving work opportunities for disabled people. Research evidence on certification practice, coupled with a better understanding of the factors that can create and perpetuate sickness absence from work, suggest possible areas for reviewing clinical practice. An agenda for improving the quality of advice provided to patients of working age in the primary health care setting will need to encompass visible professional leadership, more research into current practice, and an adequately resourced programme of education for all key stakeholders.

Keywords: *sick leave; disability evaluation; government agencies.*

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Introduction

The role of the certifying medical practitioner

In the United Kingdom (UK) certifying doctors, particularly general practitioners (GPs), provide medical advice to their patients on fitness for work. This advice initiates most periods of incapacity for work lasting for more than one week. Medical statements that doctors use to record this advice, such as form Med 3 and form Med 4, are official documents and they may be used by patients as evidence to support claims for financial benefits.[1] As well as being used by employers to support claims for company sickness benefits or Statutory Sick Pay (SSP), medical statements form a key part of the claim process for state incapacity benefits. The vast majority of such statements are issued by GPs as part of their National Health Service (NHS) duties. On average, a GP will issue around 20 statements per week, most of which will be Department for Work and Pensions (DWP) data for short spells of incapacity.

There are differences of opinion within the medical profession about the importance of the doctor's role in relation to sickness certification.[2,3] Some perceive this work to be a key part of the care which doctors provide to patients of working age, while others see it as work which lies outside 'core' primary health care activity. Most observers recognise that certification work can pose a dilemma for the GP in balancing patient advocacy with the perceived 'benefit gatekeeper' role.[4] GPs have to maintain a good relationship with their patients, and their therapeutic role requires the patient's trust.[5] Richie *et al* identified that when a GP questions the continuation of sickness statements, the trust between the patient and the doctor can be undermined.[3] Other commentators point out that GPs rarely have all the information required about their patient's occupation or workplace, and that they are not sufficiently well equipped to assess functional or occupational capacity.[6,7] However, the government has indicated that, for the present, doctors working within the NHS will retain a role in certifying incapacity, although new approaches may be tested.[8,9] Even if their statutory role were to be removed, GPs would still need to give appropriate advice to their working patients.

The Chief Medical Adviser to the DWP issues detailed guidance to doctors, based on the relevant law, about how advice on fitness for work should be given and how medical statements should be used.[1,10] A fundamental principle of the present arrangements is that such advice is provided as an integral part of the clinical management of a patient's condition, usually by the doctor with lead clinical responsibility. The certifying doctor has to consider whether advising the patient to refrain from work represents the most appropriate clinical management, and, if not, whether alternative clinical management would support work retention or vocational rehabilitation. Some commentators believe that this is one area of activity in which GPs will be able to contribute

specifically to the broader welfare reform agenda for people of working age.[11] If this is so, what factors need to be considered to ensure that GPs are able to give the most appropriate advice to patients?

Social changes over the past 20 years

In the UK there has been a change in society's attitude towards people with disabilities over the past 20 years. Policy makers and legislators are increasingly using the social or disability model in place of the classical medical or illness model.[12] The social model is particularly useful in focusing on the barriers faced by disabled people in terms of social attitudes, practice, policies, and the environment. It also provides a conceptual basis for understanding and promoting employment opportunities for disabled people.[13] The recent Disability Discrimination Act aims to provide equality of opportunity and access for disabled people. A Disability Rights Commission has also been established, with the goal of achieving a society in which all disabled people can participate fully as equal citizens. Despite this, largely as a result of huge economic changes in Britain over the past 20 years, but also as a legacy of previous policies, there are still 2.6 million people of working age who are classified by the state as incapable of work, for benefit purposes.[14] This figure represents around 10 per cent of the UK working age population and is two and a half times greater than the number registered as unemployed in 2001.

Research into the economic circumstances of disabled people has shown that employment rates remain low, at around 40%, and there has been little sign of them increasing in recent years.[15] Researchers have suggested that previous policies have paid insufficient attention to the transition between employment and non-employment, and that policies aimed at retaining disabled people in work, or returning them to work, need to focus on much more than just the medical barriers. For example, a high proportion of working-age people who become disabled were found to lack basic connectivity with the labour market in terms of skills and training. Against this, and more generally, patients have ever-rising expectations of what the social security and healthcare systems should provide.

Importance of work

In present-day western society, work occupies a major place in people's lives. The primary purpose of work may be to provide financial status and security, but work also defines the individual and his or her role in society. To a greater or lesser extent work provides an income, an activity, an occupation, a structure of time, creativity, mastery, social interaction, and a sense of identity and purpose. It is not surprising that loss of work and unemployment can have a catastrophic effect on an individual. Whatever the cause, the effects of loss of work can include poverty, social deprivation and social isolation, poor physical and mental health, and increased mortality.[15,16]

Sickness absence

The vast majority of people who are absent from work owing to sickness are away from work for a very short time, but each week in the UK around 17 000 people reach their sixth week of sick leave or SSP. Although the majority of them will return to work, around 3000 of them will move from SSP to Incapacity Benefit (IB), normally after 26 weeks on SSP. Of these, only about 300 (10%) will work again in the short term, with half of them returning to their previous employer and half moving to a new employer (figures from the former Departments of Social Security and Education & Employment).

This transition from employment to economic inactivity often represents a personal and financial loss for the individual and a loss of productive capacity for society in general. Currently there is much interest within the UK government, the healthcare professions, and others in improving vocational rehabilitation services and employers' management of sickness absence, and in reducing the incidence of long-term disability.[17-19] The UK government's strategy for reforming the welfare state for people of working age is based upon the philosophy of 'Work for those who can, security for those who cannot'. Recent government initiatives include the reform of the medical assessment for state incapacity benefits to focus more on residual capabilities rather than just incapacity, the introduction in pilot areas of employment-focused personal advisers for incapacity benefit clients, and the introduction of a tax credit for people at risk of losing their jobs because of long-term sickness or disability. From 2001, a new UK agency, Jobcentre Plus, will bring together employment and benefit services for people of working age.

Factors other than medical advice which can influence sickness absence

There is some evidence that a person is more likely to refrain from work in the short term when they fall ill where there is little or no economic loss owing to continuing pay or good wage replacement rates; where there is little disapproval from fellow workers and managers;[20,21] and where they perceive little risk of losing their job; for example, because of low unemployment or a skills shortage. In fact, a decision to stop work because of a chronic medical condition or disability is often made by the patient, with or without the advice or agreement of a health professional or employer. The key factors believed to influence this decision are: the perceived symptoms, for example, pain, disability and anxiety; the nature of the work demands; and the sociodemographic context.[20]

In poor economic times, when suitable work is scarce, particularly for older or unskilled workers, a mild degree of illness or disability may lead to long-term sickness absence in someone who would otherwise be able to continue working. Furthermore, attitudes to work among ill or disabled employees and among employers often change dramatically for employees aged 50 years or over. Early retirement on health grounds can allow a socially acceptable exit from work which can have attractions for both parties, at least in the short term.[22] There is now considerable evidence that the decision to retire early on health grounds, for example, because of chronic low back pain, is predominantly based on factors of which the medical condition is the least important.[21]

From the perspective of the social model of disability it is

recognised that there are a number of barriers which prevent people who are sick or disabled from returning to work.[23,24] Some of the barriers most frequently mentioned by disabled people and service providers are set out in Box 1. Furthermore, extensive research on patients with low back pain has demonstrated a range of factors which predict poor outcome in terms of restoration of normal function and work, including social problems, psychological distress, physical inactivity, dissatisfaction with work, compensation claims, and poor localisation of pain.[25-27]

Income replacement payments can create disincentives to work

Sickness certification provides access to financial benefits. Broadly speaking, there are two competing social goals underpinning the concept of income replacement for sick and disabled workers who are wholly or partially incapable of work:[21] to provide economic security; and to ensure that as many people (of working age) as possible remain in the workforce or are rehabilitated back to work as quickly as possible. A person who is sick or disabled and unable to work may receive income replacement from one or more of a number of sources, including employer sickness benefits, state benefits, private insurance benefits, pensions, and personal savings.

However, income maintenance payments of this sort[28] can be disincentives to resuming work. The availability of income replacement benefits may act as an incentive for workers with marginal disabilities to drop out of the work force and seek these benefits instead, particularly where there is relatively loose control of the gateway to such benefits. The receipt, or potential receipt, of disability benefits may act as a disincentive to rehabilitation. The level of income replacement benefits may act as a financial barrier, because to be financially better off, a wage plus any 'in-work' benefits must exceed the level of income from 'out of work' benefits. This may be characterised by the so-called 'benefit trap', in which disabled people find themselves unable to get a job, particularly part-time work, which will pay more than their income from being out of work. The balance of incentives may clearly influence the behaviour of a rational person and may help to reinforce the notion of incapacity for work.

- *Inappropriate early interventions.* There is insufficient help for people to retain their present job when they fall sick or become disabled. In this context the GP is often cited as a key person in managing appropriate interventions in the early stages of a spell of incapacity.
- *Assumptions of unemployability by professional advisers.* Health service users experience a clinical culture that too frequently assumes that a disabled person will never work again or, at best, sidelines any discussion of employment issues.
- *Stigma and discrimination by employers and the public.* Disabled people regularly put employers' negative attitudes high on their list of barriers to working. This is particularly the case for people with mental health problems.
- *The benefits trap.* Disabled people are understandably reluctant to risk a return to work and give up their benefits in case the job does not work out. Furthermore, users report difficulty with accessing appropriate information about in-work benefits.
- *Inter-agency problems.* Disabled people and their professional advisers report that the various agencies which provide vocational rehabilitation, including government agencies and the independent sector, rarely work together or provide maps by which individuals or their advisers, such as their GPs, can navigate 'the system'.
- *Loss of motivation and confidence.* Maintaining motivation, self-confidence, and self-belief, is considered to be an important indicator of employability. In this context the attitudes and expectations of relatives and friends are also very important.

Box 1. Barriers which prevent disabled people from returning to work, based on evidence from service users and providers.[23,24]

Skills required by the general practitioner

The essence of general practice is that the GP encompasses and integrates physical, psychological, and social factors in their considerations of health and illness.[29,30] The medical practitioner's role in the assessment of fitness for work may also be wide ranging.[31] There is a growing view that doctors should look beyond a specific disease or impairment to the effects on patients' activities and participation in society.[32,33] Musculoskeletal conditions, mental health conditions, respiratory diseases, and physical injuries, are the main medical problems which lead to a statement of incapacity being issued by a doctor. Interestingly, these are all areas which offer considerable potential for preventive and rehabilitative action by employers, employees, and healthcare services. Patients with a high probability of long-term incapacity for work in the UK are those with musculoskeletal disease, mental illness, and circulatory disease.[14]

The quality of the advice given to patients on their fitness for work depends to a large degree on the skills of the doctor in managing these clinical areas and in addressing the relevant occupational factors. There is limited evidence available about the quality of the service which patients of working age currently receive from certifying doctors in the UK. However, research conducted for the UK government a decade ago,[3] more recently,[34] and by others,[35] suggests that GPs generally have low expectations of their patients returning to work, a rather poor understanding of their responsibilities as certifying medical practitioners, and often negative experiences of the vocational rehabilitation services which are available to their patients. Others have raised concerns that GPs may not have an adequate understanding of the certification system[36] and that they may learn this aspect of their work by trial and error.[6]

There is also some evidence that GPs may be failing to recognise clinical conditions which frequently lead to work incapacity, such as depression and osteoarthritis.[37,38]

Evidence-based guidelines on clinical management have been developed for conditions which commonly lead to work incapacity, for example, low back pain,[39] but there is little evidence that these guidelines meet the specific needs of certifying doctors or that they are being applied in a way that will produce the maximum benefit for patients of working age.[40]

Some work from Scandinavia indicates considerable variation in certification practice between individual doctors. For example, older doctors and those consulting at a higher rate per hour issue more certificates, and doctors with a high level of postgraduate training issue fewer certificates.[41] The guidance issued to registered medical practitioners by the

DWP sets out the factors which doctors should consider when advising patients on fitness for work. From this it is possible to identify the type of knowledge and skills required by doctors who provide their patients with such advice (Box 2). Many of these skills are 'generic' and are required by GPs for all aspects of their clinical practice. Other skill areas require a better understanding of occupational health issues. Ritchie *et al* mention some of the areas of greatest uncertainty for GPs when advising patients about a return to work, particularly the potential for alternative occupation or for other occupational rehabilitation.[3]

Managing the sick role in patients of working age

It is relevant for certifying doctors to have an understanding of the sick role and the factors which influence its development in patients of working age. The onset of illness triggers a social process that in turn shapes a person's response to their medical condition. The sick role is not itself a medical diagnosis, but rather a status accorded to the individual by other members of society that may be variably associated with a medical condition.[42] Social theorists stress that the sick role is an acceptable adaptation to dealing with role impairment as a result of illness.[43] The individual will accept and adopt the sick role and, particularly in relation to work loss or obtaining financial benefits, there is often medical certification to legitimise the role. For doctors who legitimise the sick role in this way, albeit with the best intentions, the long-term consequences for the patient and their family are not always apparent.[44]

It is possible to define certain social rights and duties of the person in the sick role.[45,46] A reasonable starting assumption, at least for acute physical disease and injury, might be that disease or disability is something unfortunate that occurs outside the individual's control and involves some degree of helplessness. However, in the case of chronic disease, expectations of health care and residual disability have to be modified in the light of what has actually happened to the individual. Furthermore, in chronic disability the person's beliefs and behaviour are often part of the problem. A combined model of the 'rights' and 'responsibilities' which may relate to a person adopting the sick role, based on the work of Parsons and Waddell *et al*, can be postulated (Box 3).

There has been some criticism of the concept of the sick role; for example, that more recent ideologies of patient empowerment challenge the dependency relationship which is implied by the sick role,[47] but the concept remains useful. The challenge for GPs as clinicians and as certifying doctors is to manage the patient's condition and expectations in a way that produces the best overall outcome for the patient within available resources. Blackwell has suggested techniques for clinicians to help them manage the sick role. The approach suggested may help to maximise the patient's expectations of recovery, their capacity for work, and minimise chances of long-term disability[48] (Box 4).

Conclusion

The issues set out here, along with the medical profession's drive for improvement in the quality of primary care and the increasing expectations of society, suggest quite a challenging agenda for change. This will need to encompass:

- professional ownership and leadership in relation to advice on work and incapacity certification, with an appropriate academic and research basis;
- improved training on occupational health issues, both for established doctors and doctors in training, through appropriate undergraduate and postgraduate education

Factors a doctor should consider when advising patients on fitness for work based upon current DWP guidance for certifying doctors.	*Relevant knowledge and skills*
• the nature of the patient's medical condition and how long the condition is expected to last	• skills as a diagnostician and in assessment of functional disability • skills in accessing data about appropriate periods of incapacity; for example, for different medical conditions and surgical procedures • skills in referring for specialist advice
• functional limitations which result from the condition, particularly in relation to the tasks the patient performs at work	• skills in functional disability assessment • skills in taking an occupational history • knowledge of the workplace and relevant occupational health issues or ability to access appropriate sources of expert advice
• any reasonable adjustments that might enable the patient to continue working	• an understanding of the needs of employers and employees • knowledge of relevant UK law such as the Disability Discrimination and Health and Safety at Work legislation and its related guidance
• appropriate clinical guidelines	• awareness of, and ability to apply, current evidence-based guidelines to clinical practice
• clinical management of the condition which is in the patient's best interest regarding work fitness	• skills in therapeutics and current best clinical practice • knowledge and understanding of local rehabilitation and employment related services • skills in enabling the patient to access appropriate services
• managing any conflict of interest between the GP's caring/advocacy role and the patient's need for economic support or compensation	• knowledge of roles and responsibilities of the certifying doctor, the employer and the various other agencies involved • skills in negotiation and managing confrontation
• managing the patient's expectations in relation to his or her ability to continue working	• skills in couching clinical diagnoses in terms of physical, mental and social parameters • skills in clinical consultation and eliciting any 'hidden agendas'

Box 2. Clinical knowledge and skills relevant to sickness certification.

'Rights'	*'Responsibilities'*
1. The sick person is not responsible for the original medical disease or injury	1. The sick person accepts obligations either to try to get well *or* to reduce illness behaviour and disability as much as possible
2. The sick person is entitled to support and attention over and above that given to a 'fit' person	2. The sick person may modify their normal social obligations to a degree proportionate with their illness
3. The sick person must at least share responsibility for his/her own health and disability	

Box 3. Balancing the 'rights' and 'responsibilities' of a person adopting the sick role.

Feature	*Management by doctor*
• disproportionate disability to disease	• thorough medical assessment
• search for validation of disease	• redefinition of symptoms (without challenging the patient's reality)
• appeal to doctor's responsibility	• transfer to patient responsibility
• patient helplessness/vulnerability	• symptom control, encouragement of self management
• primary gain in avoidance of healthy role	• enhancement of healthy role
• interpersonal behaviour sustaining sick role	• doctor behaviour to minimise sick role
• environmental rewards for sick role	• redeployment of environmental rewards

Box 4. Managing the sick role, after Blackwell .[48]

mechanisms to support high quality clinical care for working patients;
- better information on current practice and performance in the area of certification and perhaps greater recognition of this aspect of practice in professional development plans;
- improved guidance for doctors to help them better understand their role in the certification process, possibly linked in the future to nationally applicable revalidation criteria relating to this area of work.

Allied to these issues is the broader requirement for:

- improved clinical support from occupational health and rehabilitation services for patients and certifying doctors, as part of the development of primary care trusts;
- further research into the healthcare factors which can help a worker to remain in employment when they fall sick or become disabled;
- better education on fitness for work issues for patients and their employers.

Significant funding and development on all of these fronts will be required if general practitioners and other members of the primary health care team are to play a full part in supporting the broader welfare reform agenda for their patients of working age.

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